



ALASKA'S

MEDICAL ASSISTANCE PROGRAMS

Medicaid ✧ Denali KidCare ✧ CAMA



Providing health coverage for Alaskans in need.

May 2003

Please note the following changes to Alaska's Medical Assistance Programs booklet published May 2003:

Effective July 1, 2003

The Division of Medical Assistance was renamed **The Division of Health Care Services**. The address, 4501 Business Park Blvd., Suite 24, Anchorage, Alaska 99503-7167, remains the same.

The Alaska Medicaid website address is now:

<http://www.hss.state.ak.us/dhcs/Medicaid/default.htm>

Effective February 23, 2004

The Medicaid Hotline in Anchorage and toll free (statewide) was renamed **Recipient Information Helpline**.

The new phone numbers are:

In Anchorage: 339-1932, and

Nationwide calls, including outside of Anchorage:

1-800-780-9972.

May 2003

Dear Reader,

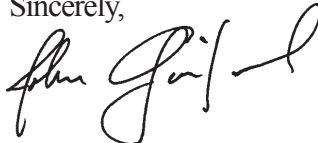
As Director of the Division of Medical Assistance, I am pleased to provide you with this booklet of information regarding health care programs for Alaskans in need.

The purpose of this booklet is to help you understand available programs and, if you are eligible, how to use the coverage effectively. If you have questions regarding any aspect of the programs, please call the Division of Medical Assistance Hotline, toll free at 1(800)211-7470 (statewide); if you live in the Anchorage area, you may call 562-3671 or 334-2398.

It is important to understand that this is only a guide and is not intended to determine eligibility. Each person's situation is different. There are many factors which must be taken into consideration. Final determination of eligibility will be made by the Division of Public Assistance (please see the back page of this booklet for the nearest office).

Our programs help you take responsibility for your own health by paying for a wide variety of services. To get the most benefit, you should follow the guidelines, use the services wisely, and most importantly, lead a healthy lifestyle. By doing these, you will help to maintain the integrity of Alaska's medical assistance programs.

Sincerely,

A handwritten signature in black ink, appearing to read "John Gaisford", with a stylized flourish at the end.

John Gaisford, Director
Division of Medical Assistance

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This booklet contains information about the Medicaid, Denali KidCare and Chronic and Acute Medical Assistance (CAMA) programs. The programs have many features in common. The “Common Program Features” section on page 4 applies to all three programs. On the pages following the Common Program Features section, each program is discussed separately.

This booklet is published by the State of Alaska, Department of Health and Social Services, Division of Medical Assistance.



GENERAL INFORMATION

INFORMATION ABOUT MEDICAL ASSISTANCE PROGRAMS IN THIS BOOKLET

WHAT DO THE MEDICAID, DENALI KIDCARE AND CAMA PROGRAMS HAVE IN COMMON?

Alaska Medicaid, Denali KidCare and CAMA are all medical assistance programs administered by the State of Alaska, Division of Medical Assistance, to assist individuals and families with health care coverage. All programs include responsibilities for recipients and health care providers, guidelines for use, and general program information.

COMMON PROGRAM FEATURES

WHEN YOU USE MEDICAL ASSISTANCE, YOU MUST:

- Tell the Division of Public Assistance and your provider if you have any other type of health care coverage. Give the policy number and any other identifying information they might need.
- Make sure your health care provider will accept Alaska Medical Assistance as a health coverage program.
- Make sure the service you receive is covered by Medical Assistance.
- Show your health care provider your current Recipient Identification Card each time you receive medical treatment.
- Report to your caseworker any change in your income, assets, place of residence, if anyone has moved into or out of your home, or anything else that could affect your eligibility for coverage.
- Pay the co-pay amounts for certain services and drugs.
- Pay for your medical care if you get services from a provider who is not enrolled with Alaska Medical Assistance, or services that are not covered by Alaska Medical Assistance.
- Talk to your health care provider about any problems you have with your medical bills.

YOUR MEDICAL ASSISTANCE HEALTH CARE PROVIDER MUST:

- Accept your Medical Assistance card/coupon as full payment for covered services.
- Get payment from Medical Assistance or your health insurance company.
- Accept only the Medical Assistance rates for your health care. Alaska Medical Assistance will only pay a certain amount of money for each health care service, and your provider cannot charge you or the state more than that amount.
- Collect the co-pay amount you are required to pay.
- Receive prior authorization for some services.

Health care providers who knowingly charge Medical Assistance for services that were not given, who neglect or abuse patients, or give poor quality care may be subject to legal action. If you believe this has happened, you may write the Division of Medical Assistance, 4501 Business Park Blvd., Suite 24, Anchorage, Alaska 99503-7167. You may also call the Medicaid Hotline toll free (statewide) at 1-800-211-7470. In Anchorage, call 562-3671 or 334-2398.

HOW DO MEDICAL ASSISTANCE PROGRAMS WORK?

For each month you are eligible for Medicaid, Denali KidCare or CAMA, you will receive a Recipient Identification Card, sometimes called a coupon. *You must show your recipient card to your physician or other health care provider each time you receive medical treatment.* You are liable for the full cost of your treatment if you fail to show proof of eligibility to the provider at the time services are provided to you, so be sure to take your card with you whenever you visit your health care provider. Your provider will send a bill directly to the Division of Medical Assistance for payment. For some services, you may be required to share the cost. You should *not* pay your provider for the full cost of services you receive because Medical Assistance cannot pay you back.



COULD I LOSE MY ELIGIBILITY?

It is possible for you to lose your Medical Assistance eligibility for a variety of reasons. Here are some common ones:

- You lose your status as a resident of Alaska
- Your income or assets increase
- Your household composition changes
- You lose your disability status
- You fail to cooperate with the Child Support Enforcement Division (CSED) when required
- You do not provide your caseworker with your current or a forwarding address
- Your age makes you ineligible for certain Medical Assistance categories
- You are untruthful about your Medical Assistance application or you knowingly break Medical Assistance rules

If you are unsure about your eligibility or what may cause you to become ineligible, contact your caseworker.

WHAT IS “PRIOR AUTHORIZATION?”

Some services covered by Medical Assistance must be “prior authorized.” This means that you must receive approval from Medical Assistance before receiving a service. Your health care provider is responsible for requesting prior authorization for services he/she will perform. Transportation must also be prior authorized. It is the provider’s responsibility to get authorization for travel.

SHOWING UP FOR APPOINTMENTS

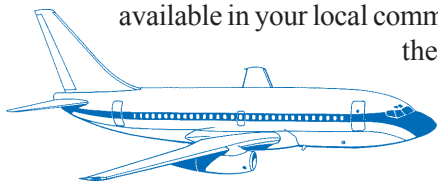
It is very important to arrive for your appointment several minutes before it is scheduled. If you are unable to make it to your health care provider’s office on time, you need to call as soon as you can (at least 24 hours beforehand if possible) and let them know that you are not going to be able to keep your appointment. Your provider has set aside time for you in order to treat you. Please be courteous to your provider and arrive several minutes before your scheduled appointment or give at least a full day’s notice if you must cancel.



TRAVELING ON MEDICAL ASSISTANCE AND HOW IT WORKS

Your health care provider may decide that you need to go to a different

community for health care services. Medical Assistance may pay for travel to the nearest facility that can provide services that are not available in your local community. Your local provider will contact



the Division of Medical Assistance (or its designee) for your travel authorization, but it is your responsibility to make all travel

arrangements. Your appointment must be with an Alaska Medical Assistance provider at a specific date and time. If the travel is for a child under 18, an escort's travel will also be requested.

An escort may be requested for adults traveling to or from a medical appointment. A medical escort is authorized for travel, lodging, and meals during the time medical evaluation and treatment are being provided.

A medical escort is authorized for the following recipients:

- All Medical Assistance eligible children under the age of 18
- Medical Assistance eligible recipients over 18 if the referring or treating physician indicates that an escort is medically necessary

Once your trip is approved, you will be given a travel voucher. Be sure to have several copies of your travel voucher with you because you must give one copy of the voucher and one Medical Assistance sticker from your Recipient Identification Card to each airline, ferry, taxi, or hotel that you use. Not all airlines, hotels, or taxis will take your Medicaid coupons.

On overnight trips, Medical Assistance will pay up to \$36.00 for food each day. You must pay any amount over that. It is highly recommended that you stay at a Medicaid approved hotel which has a restaurant so that your room and meals can be paid for at the end of your stay with your voucher and stickers. When making reservations, be sure to ask the hotel and restaurant if they will accept Medical Assistance as payment for services.

If you travel with an escort, it is expected that the escort will be able to share your hotel room. Separate rooms are not routinely authorized for escorts. The escort should be appropriate to share accommodations with you. The Division of Medical Assistance will review requests for separate rooms when there are unusual circumstances.

The Division of Medical Assistance will *not* pay for:

- Your food or lodging if you stay with friends or family

- Travel expenses that have already been paid by you
- Travel expenses that are not approved before you travel (except in emergencies)
- Hotel and hospital expenses that cover the same time period (be sure to check out of your hotel before you check into the hospital)

If you are traveling for medical care outside of Alaska you may want to ask your Division of Public Assistance caseworker for extra stickers before you travel. A request for out-of-state services requires a medical provider referral and medical justification. The provider must state that the covered services are not available in Alaska. Your medical provider should request prior authorization for a diagnosis or procedure *before* requesting authorization for out-of-state services. If you are traveling at the end of the month and expect to be gone into the next month, be sure to ask for extra stickers for the next month.

MEDICAL ASSISTANCE RECIPIENT TRAVEL TIPS

- Be sure your appointment is medically necessary. This means that you have seen a local health care provider who has referred you for medical treatment outside your home community.
- Be sure that your travel has been approved (prior authorized) *before* you travel.
- It is your responsibility to make your travel and lodging arrangements.
- Make your reservations only for days that have been approved. Travel on weekends is generally *not* approved.
- Keep all your travel paperwork in a safe place.
- Bring money for items that are not covered by Medical Assistance. These items include: room service, tips, phone calls, pay-per-view movies or movie rentals and other non-essential expenses.
- Bring personal identification
- Bring your Medical Assistance identification card/coupons. You are responsible for showing your card for all appointments. If a provider cannot confirm your eligibility, you can be held responsible for the cost of services.

more travel tips...

...more travel tips

- Bring the Alaska Medical Assistance Recipient Hotline number with you: 1-800-211-7470 toll free in Alaska or 562-3671 in Anchorage or 334-2398.
- If the health care provider you've traveled to see determines that your travel needs to be extended or weather prevents travel, that provider needs to contact the Prior Authorization Unit at First Health to arrange for an extension.
- If you do not travel and have unused tickets, return them to the local health care provider who arranged the travel authorization.

WHERE CAN I ASK QUESTIONS ABOUT MEDICAL ASSISTANCE PROGRAMS?

For questions about Medicaid, Denali KidCare and CAMA services, such as covered services, health care providers and billing issues, you may call the Medicaid Hotline toll free (statewide) at 1-800-211-7470. In the Anchorage area you can call 562-3671 or 334-2398. If you have Internet access, you may view the Division of Medical Assistance homepage at <http://www.hss.state.ak.us/dma> for more information regarding possible health care options for Alaskans in need.



Depending on the type of question you have, you may want to call either the Division of Medical Assistance (Medicaid) or the Division of Public Assistance (DPA). The Division of Medical Assistance (DMA) can help you with questions about what types of services are available to you and help you to get the services you need. The DPA offices can help you with questions about eligibility for programs, replacing lost cards and giving you information about your caseworker and your case(s).

Division of Public Assistance (DPA) Interactive Voice Response: 1-888-804-6330 statewide and 269-5777 in Anchorage. If you want case information, the system will tell you to enter your security code. Your security code is the last 4 digits of your Social Security Number. (Phone numbers for regional DPA offices are listed at the back of this booklet).

The Division of Public Assistance Interactive Voice Response (IVR) system will allow you to receive the following information:

- 1) Your caseworker's name and number
- 2) Your case information
- 3) Description of public assistance programs
- 4) Location and phone number(s) of public assistance offices

Once you have your caseworker's name and number, you can call the Division of Public Assistance for:

- Eligibility questions (program requirements, retroactive eligibility, income guidelines, etc.)
- Questions about lost cards/coupons
- Reporting a change of address, household composition, or income
- Reporting the birth of a child

Call the Medicaid Hotline for:

- Coverage and Benefit questions (including questions about denial of services).
- Billing inquiries
- Questions about travel procedures
- Fair hearing requests when a service has been denied

Division of Medical Assistance (DMA): 1-800-211-7470 statewide, and 562-3671 or 334-2398 in Anchorage

HOW DO I REQUEST A FAIR HEARING?

You may request a fair hearing in the following situations:

- 1) Your *application* for Medicaid, Denali KidCare or CAMA was denied
- or
- 2) You participate in a Medical Assistance program, but were denied a *service or coverage* under Medicaid, Denali KidCare or CAMA
- 3) If you believe your application for a Medical Assistance program was denied in error, contact the public assistance office where your application was processed and tell them you would like a hearing. The public assistance offices are listed at the back of this booklet.

- 4) If you are already a recipient and were denied a service that you believe should have been covered by Medical Assistance, you may contact the Division of Medical Assistance to request a fair hearing. Contact the Fair Hearing Representative at the address and/or phone number below:

Fair Hearing Representative
Division of Medical Assistance
4501 Business Park Blvd., Suite 24
Anchorage, AK 99503-7167
(907) 334-2415 or 1-800-211-7470

MEDICAID

WHAT IS MEDICAID?

Medicaid is like health insurance but it is available only to certain low income individuals and families who fit into an eligibility category recognized by federal and state law. Medicaid does not pay money to you, instead, it sends payments directly to your health care providers.

Medicaid is often confused with **Medicare**. The basic difference is that eligibility for Medicaid is based on financial need. Medicare is not based on financial need, but is available to individuals who qualify by having worked and paid into the Social Security system. Generally, Medicare is available to people receiving Social Security Disability Income (SSDI), or those aged 65 and older who are also receiving Social Security payment. In some cases, Qualified Medicare Beneficiaries (QMB) may receive assistance from Medicaid to pay for all or part of Medicare's deductibles and co-payments. For more information on Medicare, please call the Alaska Medicare Helpline toll free at 1-800-478-6065.

WHO IS ELIGIBLE FOR MEDICAID?

To be eligible for Medicaid you must fit into an eligibility category. Generally, the categories of eligibility are children, pregnant women, families with dependent children, disabled adults, or persons age 65 or older. This leaves out many people, such as single adults who are not disabled and who do not have children at home. These people cannot qualify for Medicaid even if they are low income and have large medical bills.

You must be financially eligible for the Medicaid program. The rules for counting your income and assets vary from category to category and can get rather complex. There are special rules for those who live in nursing homes and for disabled children living at home. Your caseworker will evaluate your financial eligibility for you.

HOW DO I APPLY FOR MEDICAID?

You can pick up an application at your local DPA office or its representative

in your community, called a “fee agent.” Some hospitals and doctors’ offices also have applications available. The completed application must be submitted to the nearest Division of Public Assistance office or fee agent. Arrangements will be made for an interview, if necessary. Both the application and interview are confidential.



Using eligibility rules established by the federal government and the state Division of Medical Assistance, a DPA caseworker will determine whether you and/or your family are eligible for coverage. For some eligibility categories, other state agencies and medical organizations will also review your application. Your caseworker will be looking at many things when determining your eligibility, including:

- Income
- Your personal assets (such as bank accounts, vehicles and property)
- Citizenship or alien status
- Alaska residency
- Age of each person in your household
- Special health care needs

As the caseworker reviews your application, you may be asked to provide more information. If you qualify for Medicaid coverage you will be notified by mail and sent a Recipient Identification Card. If you do not qualify you will be notified by mail explaining why. You may apply for Medicaid again at any time.

If you have been denied eligibility for a medical assistance program, you may request a hearing to appeal this denial. Please contact the Division of Public Assistance (DPA) caseworker who evaluated your application for information about how to request a hearing.

WHERE DO I GO TO APPLY FOR MEDICAID?

You may go to any Division of Public Assistance office listed on the back page of this booklet to apply for Medicaid. If you live in a community not listed, there may be a fee agent available to help you apply. To find out if you have a fee agent, contact the nearest Division of Public Assistance office.

WHAT IF I HAVE MEDICAL INSURANCE OR HEALTH COVERAGE?

Generally, Medicaid is the “payer of last resort.” This means that if you have other health insurance or belong to other programs that can pay a portion of your medical bills, payment will be collected from them first. Medicaid may then pay all or part of the amount that is left. If you are covered under the Indian Health Service (IHS), the IHS is the payer of last resort.

This is very important: When you apply for Medicaid, you **MUST** indicate if you have any other type of health care insurance or benefits. If you fail to tell your caseworker about your other health care coverage, you may be responsible for part of your medical bill. Your Division of Public Assistance caseworker can help you determine if you have any other type of health care coverage.

Other sources of health coverage include, but are not limited to:

- Private health insurance
- Veterans Administration (VA) benefits
- Medicare
- TRICARE
- Medical support from absent parents
- Court judgments or liability settlements for accidents or injuries
- Workers’ compensation
- Long-term care insurance
- Fisherman’s Fund (for commercial fishermen in Alaska)

WILL I HAVE TO PAY ANYTHING FOR SERVICES?

You may be required to share the cost for some services that you receive. Your “co-pay” amounts may include:

- \$50.00 a day up to a maximum of \$200.00 per discharge for inpatient hospital services
- \$3.00 for each visit to a health care provider or clinic
- 5% of the allowed amount for outpatient hospital services (except emergency services or admissions through an emergency room)
- \$2.00 for each prescription drug that is filled or refilled

You pay the co-payment amount directly to your health care provider when you receive services. If you cannot pay *at that time*, you will still receive services. Your provider will bill you for the co-pay amount. If you do not

pay your co-payments when you are billed, and your provider has a policy to refuse services to any client who has an outstanding balance, your provider may refuse to see you for future appointments.

Children under 18, pregnant women, and people in nursing homes are not required to pay co-payments. Certain services such as family planning services and supplies, emergency services, and hospice care do not require a co-pay payment. If you are pregnant, notify your Division of Public Assistance caseworker right away. Your coupons can be changed to show that you are pregnant so that you will not have to pay the co-pay amount.

WHAT SERVICES WILL MEDICAID COVER?

A brief definition of the services covered by Medicaid for eligible recipients is explained below. Some services have limits and others must be prior authorized before they are provided. In addition to the covered services listed here, children receive additional and/or expanded services (See “*Additional Services for Children*” on page 20).

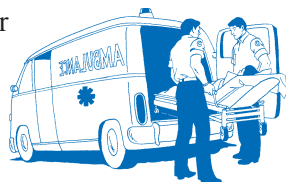
Audiology & Treatment of Speech, Hearing and Language Disorders. Medicaid will cover services of a speech therapist to improve a person’s ability to speak, or an audiologist to test a person’s hearing. Medicaid will also pay for hearing aids, which are limited to a certain model. Batteries and repairs are covered.

Dental. Medicaid covers limited services for adults that include the *minimal* treatment for relief of pain and infection. This usually means fillings and/or extractions are covered. Crowns, root canals, and dentures are not included.

Dialysis. Medicaid will cover services provided for treatment of kidney disease that would cause kidney failure if left untreated. Services are covered whether received in a hospital or free-standing agency.

Durable Medical Supplies and Equipment. Medically necessary supplies and equipment are covered if ordered by your physician and approved by Medicaid. Some supplies and equipment require prior authorization.

Emergency Services. Medicaid will cover immediate medical care that is necessary when a sudden, unexpected occurrence creates a medical emergency. A medical emergency exists when there is a severe, life-threatening or



potentially disabling condition that requires medical intervention within hours. If the services do not meet the definition of emergency services you will be required to pay the co-pay amount for physician services and hospital outpatient care. If use of an ambulance is determined not to be an emergency, Medicaid might not pay the bill, and you may be held responsible for the amount due.

Family Planning Services and Supplies. Family planning, medical counseling services, and the cost of birth control for men and women are covered services. Medicaid covers many over-the-counter birth control items, such as contraceptive creams, gels, foams, and condoms if your health care provider writes a prescription for them. These supplies are also available free from family planning clinics in larger towns.

Home and Community Based Care Services. People of any age who experience long term medical conditions that require a level of care offered in a nursing home, and those with mental and/or developmental disabilities that could be served in an institution may be able to get their care at home through the Home and Community Based Care Services programs. These programs are often called “waivers.”

People age 0-21 with complex medical care needs, and individuals of any age who are mentally and/or developmentally disabled are served by:

Division of Mental Health and Developmental Disabilities (DMHDD)

Phone: (In Anchorage) 907-269-3600 or

toll free (statewide) 1-800-770-3930

Hearing impaired, TDD (907) 269-3624

People age 21 and older experiencing medical problems, who would otherwise qualify for care in a nursing home, are served through:

Division of Senior Services (DSS)

Phone (Anchorage) 907-269-3666 or

toll free (statewide) 1-800-478-9996

Waiver recipients receive medical care through Medicaid health care providers as described in this document in addition to specialized waiver services. Specialized waiver services are not available to people receiving regular Medicaid.

Home Health Care. Part-time nursing care prescribed by a physician and provided to a person at home may be covered by Medicaid. Home health care must be prior-authorized by Medicaid before care starts.

Hospice Care. Special services for persons who are terminally ill can be provided at home through a hospice care agency. A physician must order these services, and the patient or family must sign an agreement with the hospice to receive care at home.

Hospital Care. The care you receive at a hospital must be for a Medicaid approved service, and some services must be prior-authorized. This care may be for both inpatient and outpatient services. If you must stay in the hospital (inpatient), Medicaid will pay for a semiprivate room. Payment is made for a private room only if your physician says you need it *and* Medicaid approves it. Telephone calls, television, and other personal items are not covered by Medicaid. If you must receive treatment at a hospital but you do not have to stay in the hospital (outpatient), Medicaid will pay for the treatment. Your physician must schedule this care with the hospital. Emergency room services are covered.

Inpatient Psychiatric Facility Services. These services are only for people who are under age 21, or 65 and over. Prior authorization is needed.

Laboratory and X-ray Services. Diagnostic tests and procedures such as laboratory tests, examinations, and X-rays are covered when they are ordered by your health care provider.

Mammography Screening. Breast X-rays are covered by Medicaid if your health care provider orders them.

Mental Health Services. Psychotherapy services provided by a psychiatrist are covered. Services provided by a psychologist or clinical social worker employed by a community mental health clinic are also covered.

Nurse Practitioner Services. The services of an Advanced Nurse Practitioner are covered.

Nursing Facilities Services. Prior authorized nursing home care is covered.

Occupational Therapy. Occupational therapy is covered when medically necessary to correct a physical defect.

Personal Care Services. Medicaid covers the services of a personal care assistant who comes into the home to perform medical and non-medical tasks for recipients who qualify.

Physical Therapy. Medicaid will cover some services of a physical therapist to rehabilitate and restore body functions following an illness or accident if ordered by a health care provider. Subject to limitations.

Physician/Advanced Nurse Practitioner Services. Physician and Advanced Nurse Practitioner (ANP) services provided to you in the health care provider's office or the hospital are covered. If your provider sends you to a consultant or specialist, Medicaid may also pay for these services.

Prenatal and Postpartum Care (for pregnancy). Medicaid covers regular checkups and other services provided by a physician, clinic, Advanced Nurse Practitioner, or direct entry midwife during pregnancy and for two months after the baby is born. Medicaid also covers hospital care for the birth.

Prescribed Drugs. Most prescription drugs are covered. Some over-the-counter drugs such as birth control, prenatal vitamins, drugs for yeast infections, laxatives, etc, may be covered if they are prescribed by your health care provider. Check with your provider about drugs that will be covered by Medicaid. Except for children (under 18) and pregnant women, a \$2.00 co-payment is applicable.



Prosthetic Devices. Medicaid will cover prosthetics (artificial limbs) and orthotic devices (body braces) when medically necessary and ordered by your health care provider.

Speech Therapy. Evaluations and therapy are covered. Evaluation and treatment for swallowing dysfunctions is also covered.

Substance Abuse Rehabilitative Services. Medicaid covers certain substance abuse treatment services, depending on the treatment provider's certification. These services are:

- Assessment services to determine the nature of the substance abuse problem.
- Outpatient counseling services that allow a substance abuse client to live at home while receiving outpatient services.
- Residential treatment during which the substance abuse client resides at a substance abuse treatment center while receiving services.
- Medical services, including detoxification & methadone maintenance.

Substance abuse treatment is available for adults, teens, and pregnant women. Certain substance abuse treatment facilities have programs that allow young children to stay with their mothers at the facility during treatment.

Substance abuse treatment providers must be certified by the Division of Alcoholism and Drug Abuse (ADA) and receive funding from ADA or the DHSS. Treatment services must be medically necessary. Travel to enrolled treatment providers must be approved by ADA (1-800-478-7677).

Surgery. Medically necessary surgery ordered by a physician can be covered whether performed in a hospital or a surgery center. Some surgical procedures require prior authorization. Cosmetic and experimental surgeries are not covered.

Transportation. If your health care provider says it is necessary for you to travel outside your home area for medical services, your travel must be prior authorized and you must travel on a commercial carrier such as an airplane, ferry, taxi, etc. Medicaid may also pay for the cost of hotels, meals and taxis while you are away from home. (See “*Traveling on Medical Assistance and How it Works*” on page 6).

Vision Services and Eyeglasses. Medicaid will cover one vision examination per calendar year by an optometrist or an ophthalmologist to determine if glasses are required and for treatment of diseases of the eye.

Medicaid will pay for one pair of Medicaid approved glasses per calendar year. Additional vision coverage may be authorized if medically necessary. Tinted lenses and contact lenses are only covered for recipients with certain medical conditions.

ARE THERE SERVICES THAT MEDICAID DOES NOT COVER?

Medicaid covers most medical services for eligible recipients, but there are some services the program does not cover. These include, but are not limited to: dentures for adults; smoking cessation products and services; experimental procedures; infertility services; procedures, services and drugs related to obesity and baldness, heart transplants for adults; cosmetic surgery; and educational services. If you need to have a procedure or service but are not sure if Medicaid will cover it, please call the Medicaid Hotline toll free in Alaska at 1-800-211-7470. If you live in the Anchorage area you may call 562-3671 or 334-2398.

ADDITIONAL SERVICES FOR CHILDREN

In addition to services provided for adults, the following Medicaid services are available only to children and youth under the age of 21.

Chiropractic Services. Medicaid will cover twelve visits per child per year. Visits for children under 6 must be approved in advance by Medicaid. Services are limited to manual manipulations of the spine to correct a subluxation (dislocation) that can be verified by X-ray. Medicaid will pay for one X-ray per person per year.

Dental Services Including Dentures. Emergency, routine, and preventative services adequate to restore and maintain dental function are covered for children. Exams, X-rays, scaling, polishing, fluoride treatment and sealants are covered. Dentures, crowns, caps, root canals and oral surgery are also covered. Some services may require prior authorization.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT). EPSDT services are available to all Medicaid eligible children under age 21. (See “*EPSDT: Taking Care of Alaska’s Children*” on page 21). Children can get all the regular Medicaid services and the following special services:

- Preventive health checkups and health screening to detect health problems or concerns.
- Immunizations (shots) to prevent disease.
- Referrals for dental services.
- Diagnosis of illness or medical problems.
- Treatment of an illness or medical problem.
- Assistance with scheduling appointments and authorizing transportation.
- Follow-up with families on health checkups and treatment.

Nutrition Services for High Risk Children and Pregnant Women.

Medicaid will cover the services of a dietitian for high risk pregnant women, children who have a growth problem, chronic disease, or low weight at birth, and for adolescent girls who are pregnant or breast feeding.

Podiatrist Services. Services of a podiatrist (a doctor who specializes in conditions of the ankle or foot) are covered if the child is referred by a physician.

EPSDT: TAKING CARE OF ALASKA’S CHILDREN

Expanded services are available to babies, children and teens enrolled in Medicaid and Denali KidCare. The following services are covered until an individual is 21 years of age.

Well Child Exams. Even healthy babies, children and teens need to go to their health care provider every so often. Children go through many changes as they grow – it is important to make sure that your child is doing well. Denali KidCare and/or Medicaid pays for well-child exams that should include:

- A head to toe physical exam
- A health and developmental history
- Hearing and vision checks
- Blood tests or other tests, if needed
- Health education and guidance for parents
- Immunizations (shots), if needed
- Referral to a dentist beginning at age 3 (or earlier if needed)
- Referral to a nutrition program (WIC), if needed

Take your child for a well-child exam often, especially when they’re small. Regular visits will help make sure that your child gets his or her shots on time. These visits also give you (and your child) a chance to ask any questions you might have about your child’s health. We suggest the following well-child exam schedule:

Age	How Often Exams Should Occur
Infants	2, 4, 6, 9, 12 months
Toddlers	15, 18, 24 months
Preschool/Kindergarten	3, 4, 5, 6 years
School Age/Teens	Every 2 years, ages 7-20

Dental Health Care. Medical Assistance pays for dental health care services for children and teens. Covered services include regular dental exams, teeth cleaning, and treatment of identified oral health problems.

Local Transportation and other assistance. If you need help getting your child to health care appointments, you can get help with bus tokens, taxi vouchers or mileage reimbursement to get to your child’s medical, health screening, WIC, treatment, or dental appointments in your community. Help is also available if you need to find a medical or dental health care provider or need to make an appointment. For more information, call the Medicaid Services Program at 269-4575 (in Anchorage), or 1-888-276-0606 (toll free in Alaska).

DENALI KIDCARE

WHAT IS DENALI KIDCARE?

Denali KidCare is a program that was developed to ensure that children and teens of both working and non-working families have the health care coverage they need. The program provides comprehensive health care coverage for children and teens through age 18 and pregnant women who meet income guidelines. Please see the charts on the following page to see if your children may be eligible for the program.

WHAT ARE THE SERVICES AND BENEFITS?

Health care for your child or teen is important to prevent disease, find and treat problems early, and maintain good health. Denali KidCare children and teens receive all of the prevention and treatment services listed under “*What Services Will Medicaid Cover?*” on page 15 and “*Additional Services for Children*” on page 20.

All medically necessary services are covered for pregnant women, including prenatal care, medication, diagnostic tests, delivery costs and postpartum care. Over-the-counter prenatal vitamins are covered if you get a prescription for them from your health care provider. Nutrition services are covered for pregnant women who meet high-risk criteria. Prenatal, delivery and postpartum services can be received from physicians, nurse midwives, and direct entry midwives enrolled with Medicaid.

If you live in a community without childbirth and delivery services, Medicaid may authorize travel for prenatal care services and costs for a prematernal home stay. (See “*Traveling on Medical Assistance and How it Works*” on page 6).

Medicaid coverage continues for two months following delivery. This postpartum care allows new mothers to receive follow-up care and family planning services. Newborns automatically receive Medicaid for their first year of life. Remember to notify Denali KidCare when the baby is born so a card can be issued.



WILL I HAVE TO PAY ANYTHING FOR SERVICES?

There is no cost for eligible children, teens and pregnant women. However, recipients who are 18 years old and older may be required to pay a limited amount of the cost for some services. Your portion of shared costs is called a “co-pay” amount. Your “co-pay” amounts may include:

- \$50.00 a day up to a maximum of \$200.00 per hospital admission for inpatient hospital services
- \$3.00 for each visit to a health care provider or clinic
- 5% of the allowed amount for outpatient hospital services (except emergency services or admissions through an emergency room)
- \$2.00 for each prescription drug that is filled or refilled

You pay the co-payment amount directly to your health care provider when you receive services. If you cannot pay at that time, you will still receive services. Your provider may bill you for the co-pay amount.

WHO IS ELIGIBLE?

You will have to apply for the program to know for sure. Generally, you may be eligible if:

- you are a child or youth age 18 or younger, or you are pregnant and can provide proof of pregnancy from your health care provider, and
- you live in Alaska, and
- your family income meets the guidelines

HOW MUCH MONEY CAN MY FAMILY MAKE AND STILL BE ELIGIBLE?

Denali KidCare gross income standards are based on family size. Pregnant women and uninsured children may qualify for Denali KidCare if family income is at or below the amounts shown in Chart 1 on page 24. *Chart 1 is for families without health insurance.*

An unborn child of a pregnant woman is counted in the family size. Standard deductions per month for dependent care and work expense may be allowed. It is best to apply to see if you are eligible.

CHART 1

Family Size	Monthly Income	Annual Income
1	\$1,847	\$22,160
2	\$2,489	\$29,860
3	\$3,130	\$37,560
4	\$3,772	\$45,260
5	\$4,414	\$52,960
6	\$5,055	\$60,660
7	\$5,697	\$68,360
8	\$6,339	\$76,060
Each additional	\$642	\$7,700

*Incomes above reflect 200% of federal poverty guideline.
Effective April 1, 2002. May change without notice.*

WHAT IF MY CHILDREN ALREADY HAVE HEALTH INSURANCE?

If you have health insurance and your monthly income is less than or equal to the amounts shown below (Chart 2), your children may qualify for Denali KidCare. This program is primarily for individuals without health insurance. However, if your family income is quite low, your children with health insurance may still be eligible for Denali KidCare. You must declare current health insurance on the Denali KidCare application. If you voluntarily stop your available health insurance, there is a 12-month waiting period for Denali KidCare coverage.

CHART 2

Family Size	Monthly Income	Annual Income
1	\$1,385	\$16,620
2	\$1,867	\$22,395
3	\$2,348	\$28,170
4	\$2,829	\$33,945
5	\$3,310	\$39,720
6	\$3,792	\$45,495
7	\$4,273	\$51,270
8	\$4,754	\$57,045
Each additional	\$482	\$5,775

*Incomes above reflect 150% of federal poverty guideline.
Effective April 1, 2002. May change without notice.*

WHICH HOUSEHOLD MEMBER'S INCOME COUNTS FOR CHILDREN'S ELIGIBILITY?

Denali KidCare only counts the income of the child and the child's parent(s). The income of a grandparent, stepparent, aunt, uncle, boyfriend or girlfriend is not counted.

DO ASSETS COUNT TOWARD ELIGIBILITY?

No. Your family car, house, and other property assets do not affect your eligibility.

WHAT IF MY CHILDREN OR I AM COVERED BY THE INDIAN HEALTH SERVICE (IHS)?

Children, teens and pregnant women covered by the Indian Health Service may still be eligible.

HOW LONG DOES IT TAKE TO GET COVERAGE?

Once your application is received in the Denali KidCare office, every effort is made to determine eligibility within 30 days.

HOW WILL I BE NOTIFIED IF MY CHILDREN OR I AM ELIGIBLE?

Each child enrolled will receive a Denali KidCare Card in the mail with instructions. Pregnant women will receive peel-off stickers in the mail with instructions. You will be notified by mail if your children are not eligible.

IS THE APPLICATION PROCESS SIMPLE?

Yes. An interview is not required and the application is short. Simply fill out a Denali KidCare application, sign it, attach the required documentation, and mail it to the Denali KidCare office (Denali KidCare, P.O. Box 240047, Anchorage, AK 99524-0047). If you have any difficulty, call the Denali KidCare office for assistance.

WHERE CAN I ASK QUESTIONS OR REQUEST AN APPLICATION?

If you live in the Anchorage area, you may call 269-6529. Statewide, you may call toll free 1-888-318-8890. You may also access the Denali KidCare website at http://www.hss.state.ak.us/dma/DenaliKidCare/gen_info.htm

where you can view Frequently Asked Questions and view and/or download an application for the program. You may also email a Denali KidCare representative at: Denali_Kid_Care@health.state.ak.us.

WHAT IF MY APPLICATION IS DENIED?

If you do not qualify for the program, you may ask for a fair hearing to review your application. (See “*How Do I Request a Fair Hearing?*” on page 10).

CAMA

WHAT IS CAMA?

The Chronic and Acute Medical Assistance program (CAMA), is a state funded program designed to help needy Alaskans who have specific illnesses get the medical care they need to manage those illnesses. It is a program primarily for people age 21 through 64 who do not qualify for Medicaid benefits, have very little income, and have inadequate or no health insurance.

WHO IS ELIGIBLE?

CAMA eligibility is limited to individuals with the following conditions:

- Terminal illness
- Cancer requiring chemotherapy
- Chronic diabetes or diabetes insipidus
- Chronic seizure disorder
- Chronic mental illness
- Chronic hypertension

To qualify for CAMA a person must meet all of the requirements below:

- You must be a United States citizen or a legal alien
- You must be a resident of the state of Alaska
- You must be between the ages of 18 and 65
- Your household income must be:
 - \$300 a month or less for one person
 - \$400 a month or less for two people
 - add \$100 for each additional person

Determining an applicant's need, income and resources will include a determination of the applicant's household composition. The financial need, income and resources of a spouse, child, parent, grandparent, grandchild or sibling of an applicant will also be considered, but only if the relative has resided in the same household with the applicant for 30 days or more, does not maintain a separate residence and is financially able to provide support to the applicant. Temporary Assistance, Adult Public Assistance, and/or Supplemental Security Income does not count

toward household income.

- You must have no other third party resources you can use to pay your medical bills. Third party resources are things like:
 - Medical or hospital insurance that pays 100%, including insurance payments for accidents
 - Benefits from programs like Medicaid, Medicare, and the Veteran's Administration
 - Help from a free health clinic

You must have less than \$500 in countable resources or property that could be used to pay medical bills. Countable resources include cash, bank/credit union accounts, or personal property. Your home, income producing property, property that is used for your job (boat, fishing gear), vehicles, or fishing permits are not counted.

How CAMA WORKS

Normally, CAMA eligibility is determined for only one month at a time. Eligibility begins the first of the month *after* the month the application is submitted. There is no retroactive eligibility for CAMA. Before eligibility is determined, your Division of Public Assistance caseworker must get written verification from your health care provider that you have one of the qualifying medical conditions.

If you are eligible for the CAMA program, you will receive a Recipient Identification Card in the mail. The card will indicate the scope of medical coverage available to you. You must show this card to your hospital, health care provider, or pharmacist at the time of service. Your provider will either photocopy the card, or write down your CAMA number on the bill. Your provider will send the bill directly to Medical Assistance for payment. For some services, your provider will have to get approval for the service before you receive it. You should not pay your provider the full amount for the services you receive because CAMA cannot pay you back. You are responsible for a \$1 co-payment for any prescription drugs and \$50 per day for hospital stays, not to exceed \$200.00 per hospital admission.

WHAT MEDICAL SERVICES WILL CAMA PAY FOR?

CAMA coverage is designated by a subtype "GJ," which will be printed on your monthly coupon. Listed below are the covered services under this

subtype:

- GJ – Authorization limited to prescribed drugs, insulin and medical supplies, physician visits, prior authorized hospital, travel and skilled nursing related to your qualifying condition.

HOW TO APPLY

When you apply for CAMA, your Division of Public Assistance office will first determine if you qualify for Medicaid.

You must have an interview with a Division of Public Assistance employee or a fee agent in your community. For the interview you will need to bring the following papers along with your application:

- Papers that show your income such as tax forms, pay stubs, fish tickets, or a letter from the Internal Revenue Service saying that you do not pay taxes
- Papers that show any other resources, like savings accounts

At the interview, you will be given a form to take to your health care provider, which is used to document and verify that you have one of the covered medical conditions. Your provider will return that form to your DPA caseworker.

Your interview and your application are confidential. No one will give out information about your health or income without your permission.

Your application will be reviewed and a notice will be sent to you within 30 days.

WHAT IF MY APPLICATION IS DENIED?

If you do not qualify for the program, you may contact the caseworker who processed your application and ask for a fair hearing. (See “*How Do I Request a Fair Hearing?*” on page 10).

If you do qualify for a medical assistance program, please use this booklet as a handy reference guide to the program. Upon eligibility, you will be given case identification numbers that you may need in the future when talking to your case worker or another program person. Please feel free to use the table below to record information for each eligible person in your household.

[illegible]

DIVISION OF PUBLIC ASSISTANCE OFFICES

(If your community is not listed here, please contact the nearest office.)

Anchorage District Office

400 Gambell Street, Suite 101
Anchorage, Alaska 99501
phone: (907)269-6599

Anchorage APA Office

235 E 8th Ave., Suite 300
Anchorage, Alaska 99501
phone: (907)269-6000

Bethel District Office

406 Ridgecrest Drive
Bethel, Alaska 99559-0365
phone: (907)543-2686 or
(800)478-2686 (toll free)

Coastal Field Office

3601 C Street, Suite 410
PO Box 240249
Anchorage, Alaska 99524-0249
phone: (907)269-8950 or
(800)478-4372 (toll free)

Denali KidCare Office

PO Box 240047
Anchorage, Alaska 99524-0047
phone: (907)269-6529
(888)318-8890 (toll free)

Eagle River Job Center

11723 Old Glenn Hwy., #B-4
Eagle River, Alaska 99577-7595
phone: (907)694-7006

Fairbanks District Office

675 7th Street, Station D
Fairbanks, Alaska 99701
phone: (907)451-2850 or
(800)478-2850 (toll free)

Homer District Office

270 W. Pioneer, Suite C
Homer, Alaska 99603
phone: (907)235-6132

Juneau District Office

10002 Glacier Hwy., Suite 201
Juneau, Alaska 99801
phone: (907)465-3551 or
(800)478-3551 (toll free)

Kenai Peninsula Job Center

11312 Kenai Spur Hwy., #2
Kenai, Alaska 99661
phone: (907)283-2900 or
(800)478-9032 (toll free)

Ketchikan District Office

2030 Sea Level Drive, Suite 301
Ketchikan, Alaska 99901
phone: (907)225-2135 or
(800)478-2135 (toll free)

Kodiak District Office

307 Center Street
Kodiak, Alaska 99615
phone: (907)486-3783 or
(888)480-3783 (toll free)

Kotzebue District Office

PO Box 1210
Kotzebue, Alaska 99752
phone: (907)442-3451

Mat-Su District Office

855 W. Commercial Drive
Wasilla, Alaska 99654
phone: (907)376-3903 or
(800)478-7778 (toll free)

Muldoon One Stop

1251 Muldoon Rd., Suite 111B
Anchorage, Alaska 99504
phone: (907)269-0000

Nome District Office

PO Box 2110
Nome, Alaska 99762
phone: (907)443-2237 or
(800)478-2236 (toll free)

SE APA/Specialized Medicaid

10002 Glacier Hwy., Suite 105
Juneau, Alaska 99801
phone: (907)465-3537 or
(800)478-3537 (toll free)

Sitka District Office

201 Katlian Street, #107
Sitka, Alaska 99835
phone: (907)747-8234 or
(800)478-8234 (toll free)